Print Reset

# SELF-INSURER REQUEST
# TO ADD OR DELETE SUBSIDIARY/AFFILIATE

**Michigan Department of Labor & Economic Growth**
**Workers' Compensation Agency**
**Self-Insured Programs**
**7150 Harris Drive (48913)**
**PO Box 30016**
**Lansing, MI 48909**
**www.michigan.gov/wca**

| **Employer Records** | **OFFICE USE ONLY** Approved/Denied Effective |
|---|---|
| _____ | _____ |

| Name of Current Self-Insurer | | Federal ID # | |
|---|---|---|---|

1. This is an ☐ Addition ☐ Deletion
2. Subsidiary/Affiliate

| Name | | Federal ID # | |
|---|---|---|---|
| Address | City | State | Zip Code |

3. Entity to be added was chartered under the laws of the state of_____on_____/_____/_____.
4. Michigan Locations (attach additional sheets if necessary)

| Name | | Federal ID # | |
|---|---|---|---|
| Address | City | State | Zip Code |

5. Effective date requested: _____/_____/_____
6. Reason for addition/deletion ("acquisition", "out of business", "sold", etc.)

## FOR ADDITIONS ONLY: COMPLETE THIS SECTION

R 408.43(3) of the Worker's Disability Compensation Act of 1969, as amended states: "Separate legal entities may be self-insured under a single authority if they are majority-owned by the self-insured entity submitting the application or if the same person or group of persons owns a majority interest in each entity on a single application."

7. Does the existing self-insured employer have a majority ownership in the entity that will become self-insured?
☐ Yes ☐ No If Yes, % of ownership_____%

8. In the alternative, does the same person or group of persons own a majority interest in both the current self-insured and the entity to be added? ☐ Yes ☐ No If Yes, attached additional sheets that list the person or group of persons who own a majority interest in each entity and their % of ownership.

**NOTE: If questions 7 and 8 have both been answered: "No", the entity does not qualify for self-insured authority with the current self-insured.**

9. Will a claims payment guaranty be furnished by parent or affiliate if required? ☐ Yes ☐ No
10. Total number of Michigan employees of entity to be added _____
11. Estimated amount of Michigan annual payroll for entity to be added $_____
12. If aggregate excess insurance is required for current program, estimate increase in retention $_____

**NOTE: Please attach financial statements for the new employer if not consolidated in financial statements of the primary self-insured employer.**

| AUTHORIZED SIGNATURE | TITLE | DATE |
|---|---|---|
| | | |

| | |
|---|---|
| Authority: Worker's Disability Compensation Act of 1969, as amended<br>Completion: Mandatory<br>Penalty: Denial/Termination of Self-Insured Status | The Department of Labor & Economic Growth will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this Agency. |